Behavioral Health Clinic
DeWitt Health Care System
Child and Adolescent Psychiatry Service

Multidisciplinary Behavioral Health Assessment Patient Information Form

Please provide the following information to assist your provider in making a complete evaluation.

Name of person completing form: _____ Are you the sponsor? Yes No

Relationship to patient: Biological Mother, Biological Father, Aunt, Uncle, Step Mother, Step Father, Sister, Brother, Adoptive Mother, Adoptive Father, Grandparent, Foster Mother, Foster Father, Other _____

~~**PATIENT IDENTIFICATION DATA**~~ Date: _____

1. **Patient's Name**: _____ _____ ____
(Last name) (First name) (M.I.)

2. **Sponsor's SSN**: __ __ __-__ __-__ __ __ __ Medical Family Member Prefix (**FMP**) if known: __ __
(01 if first child, 02 if second child, 03 if third child, etc.)

3. **Patient's SSN**: __ __ __-__ __-__ __ __ __

4. **Date of Birth**: Month __ __/ Day__ __/ Year __ __ __ __ 6. **Age** _____

5. **Place of birth**: _____ 7. **Gender**: M / F

8. **Home Address**: (of patient)

Street: _____ Government Quarters? Y / N

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ - _____ **Patient's email address** (if any): _____

9. **Race/Ethnicity:** (circle all that apply)
African American or Black
Asian
Hispanic or Latino
Native American or Alaska Native
Native Hawaiian or Other Pacific Islander
White
Other _____

10. Primary **language**: _____
Other languages spoken in home? Y / N
What languages? _____
_____
_____

11. Has the child/adolescent ever been seen at Walter Reed's Child and Adolescent Psychiatry Service before? Y / N
If yes: Date? (Month, Year) __ __/ __ __ Primary Provider: _____

12. **Tricare Status** of patient: prime / remote prime / extra / standard If prime, where: _____

13. Are you currently in the family advocacy program or involved with Child Protective Services? Y / N

14. Who has legal **custody** of the patient? (Who can legally make medical decisions about the patient's care?)
(Circle all that apply)
Biological Mother, Adoptive Mother, Step Mother, Foster Mother
Biological Father, Adoptive Father, Step Father, Foster Father
Grandparent, Aunt/Uncle, Sister/Brother
Other Relative or Guardian _____, County/State, Other _____

SPONSOR'S IDENTIFICATION DATA

Sponsor's Name (Last, First, MI):_____

Sponsor's Relationship to Patient:

Biological Mother	Step Mother	Adoptive Mother	Foster Mother
Biological Father	Step Father	Adoptive Father	Foster Father
Aunt	Sister	Grandparent	Other _____
Uncle	Brother		

Currently living with patient? Y / N

Sponsor's Home Email: _____ **Sponsor's Cell Phone:** (__ __ __) __ __ __- __ __ __ __

Sponsor's Home Address (if different from patient's): Same

Street: _____

City:_____ State: _____ Zip Code:_____

Sponsor's Home Phone (if different from patient's): (__ __ __) __ __ __- __ __ __ __ Same

What is the best way to communicate with sponsor?
Work phone Work email Home phone Home email Cell Phone

Sponsor's DOB: Month __ __/ Day__ __/ Year __ __ __ __

Gender: M / F

Marital Status of Sponsor: Single, Married, Separated, Divorced, Widowed

Race: (circle all that apply)
African American or Black
Asian
Hispanic or Latino
Native American or Alaska Native
Native Hawaiian or Other Pacific Islander
White
Other _____

Primary **Language** (if other than English): _____

Branch of Service: US Army, US Navy, US Air Force, US Marine Corps, US Coast Guard, US PHS, Other _____

Rank: (E) Enlisted, (O) Officer, (W) Warrant Officer, (GS/WG) DOD Civilian

Grade: 1 4 7 10 13
2 5 8 11 14
3 6 9 12 15 SES

Duty Status: Active Duty, Retired, Reserve/Nat. Guard, DOD Civilian, Other _____

Job Title: _____ Civilian employer (if any): _____

Work Organization/Unit:_____

Work Phone: (__ __ __) __ __ __- __ __ __ __ Work Email: _____

Please select the category that best describes the Sponsor's educational attainment:

No high school diploma
High School Graduate (diploma or equivalent, for example GED)
Some college but no degree
Diploma or certificate from vocational, trade, or business school or Associate's Degree
Bachelor's degree (for example, BA, AB, BS)
Master's degree (for example, MA, MS, MEng, MEd, MSW, MBA)
Doctorate degree or Professional School degree (for example, PhD, EdD, MD, DDS, JD, etc.)

OTHER CUSTODIAL ADULT, SPOUSE, OR LEGAL GUARDIAN'S IDENTIFICATION DATA

(The person with whom the patient lives other than the Sponsor if applicable.)

Name (Last, First, MI): _____

Relationship to Patient: Biological Mother, Biological Father, Aunt, Uncle, Step Mother, Step Father, Sister, Brother, Adoptive Mother, Adoptive Father, Grandparent, Foster Mother, Foster Father, Other _____

Currently living with patient? Y / N

Currently living with sponsor? Y / N

Current Status: Civilian with military benefits; Civilian – no military benefits; Active duty / AGR

Home Email: _____ **Sponsor's Cell Phone:** (__ __ __) __ __ __- __ __ __ __

Home Address (if different from patient's): Same

Street: _____

City:_____ State: _____ Zip Code:_____

Home Phone (if different from patient's): (__ __ __) __ __ __- __ __ __ __ Same

What is the best way to communicate with other custodial adult?

Work phone Work email Home phone Home email Cell Phone

Date of Birth: Month __ __/ Day__ __/ Year __ __ __ __

Gender: M / F

Marital Status: Single, Married, Separated, Divorced, Widowed

Race: (circle all that apply)
African American or Black
Asian
Hispanic or Latino
Native American or Alaska Native
Native Hawaiian or Other Pacific Islander
White
Other _____

Primary **Language** (if other than English): _____

Job Title: _____ Work Organization/Unit:_____

Work Email: _____ Work Phone: (__ __ __) __ __ __- __ __ __ __

Was this person ever in the military? Y / N

Branch of Service: US Army, US Navy, US Air Force, US Marine Corps, US Coast Guard, US PHS, Other _____

Rank: (E) Enlisted, (O) Officer, (W) Warrant Officer, (GS/WG) DOD Civilian

Grade: 1 4 7 10 13
2 5 8 11 14
3 6 9 12 15 SES

Duty Status: Active Duty, Retired, Reserve/Nat. Guard, DOD Civilian, Other _____

Health Insurance Provider(s) (other than Tricare): None 1. _____ 2. _____

Please select the category that best describes this person's educational attainment:

No high school diploma
High School Graduate
(diploma or equivalent, for example GED)
Some college but no degree
Diploma or certificate from vocational, trade, or business school or Associate's Degree
Bachelor's degree (for example, BA, AB, BS)
Master's degree (for example, MA, MS, MEng, MEd, MSW, MBA)
Doctorate degree or Professional School degree (for example, PhD, EdD, MD, DDS, JD, etc.)

PRESENTING PROBLEM

1. What is (are) your reason(s) for bringing the child in today?

_____

_____

_____

_____

2. How long has the child/adolescent been experiencing this (these) problem(s)?

_____

_____

_____

3. Has the child/adolescent had difficulties or troubles like this before (Yes or No)? If so, please describe.

_____

_____

_____

4. What prior attempts have been made to get help with this situation? (please circle all that apply)

None	Doctor /PA /Nurse /Medic	Out patient mental health service
Friend	Chain of command /supervisor	In-patient mental health service
Family member	Police /law enforcement /MPs	Partial Hospitalization
Religious Leader /Chaplain	Legal services /JAG /IG	Residential
Other_____		Emergency Room

5. Has the child/adolescent recently experienced or presently have any of the following? (please circle all that apply)

Feeling helpless/hopeless	Physical abuse	Running away	Eating problems
Thoughts of hurting others	Sexual abuse	From home	Refusal
Thoughts of hurting self	Sexual abuse of another person	From school	Binging
Actions of self harm	Custody problems	Drug abuse	Vomiting
Actions of hurting others	School avoidance	Alcohol abuse	Fighting
Depression	Legal problems	Setting fires	Physical
Medical problems causing stress	Arrests	Cruelty to animals	Verbal
Recent history of victimization	Other	**Recent Bereavement**	
Recent Parental Deployment		**(within past year)**	
Other_____			

6. Has the child/adolescent recently experienced or presently have physical pain or discomfort? Yes No

How would you rate it on a scale of 1-10? No Pain 1 2 3 4 5 6 7 8 9 10 A Great Deal of Pain

7. What do you hope to accomplish at the initial appointment?_____

_____

_____

8. In what way(s) do you believe the clinic can be of help to you and the child/adolescent? (Circle all that apply)

Individual therapy for child	Family therapy	Psychological testing	None
Individual therapy for self	Marital counseling	Referral for substance abuse	
Group therapy	Parent counseling	Referral for _____	
Medication evaluation	Training in behavioral management	Other _____	

9. **List any psychiatric or substance abuse evaluations (past or current); counseling; and/or hospitalizations (This also includes primary care physicians and chaplains):**

Start Date	Stop Date	Location	Diagnosis (If Known)	Reason
_ _/_ _/_ _ _ _	_ _/_ _/_ _ _ _			
_ _/_ _/_ _ _ _	_ _/_ _/_ _ _ _			
_ _/_ _/_ _ _ _	_ _/_ _/_ _ _ _			
_ _/_ _/_ _ _ _	_ _/_ _/_ _ _ _			
_ _/_ _/_ _ _ _	_ _/_ _/_ _ _ _			

10. **List all past psychiatric medications, and all current medications; include over the counter medications, herbs, and supplements (i.e., St. John's Wort, Ginseng, vitamins, etc.)**

Name of Drug or Supplement	Reason	Amount Taken	Start Date	Stop Date	Effectiveness	Side Effects
			_ _/_ _/_ _ _ _	_ _/_ _/_ _ _ _		
			_ _/_ _/_ _ _ _	_ _/_ _/_ _ _ _		
			_ _/_ _/_ _ _ _	_ _/_ _/_ _ _ _		
			_ _/_ _/_ _ _ _	_ _/_ _/_ _ _ _		
			_ _/_ _/_ _ _ _	_ _/_ _/_ _ _ _		
			_ _/_ _/_ _ _ _	_ _/_ _/_ _ _ _		

Who referred the patient to CAPS: Self/Parent/Guardian Medical School Other _____

If other than self, name of referring agency/person: _____ Phone Number: (__ __ __) __ __ __- __ __ __ __

BIOLOGICAL

Please check any family history of the following problems

PATIENT'S **BIOLOGICAL** FATHER, MOTHER, and SIBLINGS (Check those which apply)

	Father	Father's Relatives	Mother	Mother's Relatives	Patient's Siblings
Family History Unknown					
Problems with aggression, defiance & oppositional behavior as a child					
Problems with attention, activity & impulse control as a child					
Problems with mood regulation / mood swings / depression					
Anxiety disorder / Nervousness					
Bizarre behavior					
Autism					
Birth defects					
Seizures / convulsions					
Muscle tics / twitches					
Rituals (hand washing / checking)					
Obsessive thinking					
Mania or bipolar disorder / manic-depression					
Learning disabilities					
Mental retardation					
Chronic health problems					
Alcohol or drug abuse					
Other addictions (gambling, smoking, etc.)					
Antisocial behavior (stealing; criminal behavior, DUI)					
Physical abuse victims					
Sexual abuse victims					
Self harm / suicide attempt / suicide					

PHYSICAL ASSESSMENT

1. Date of last physical exam: Month __ __ Year __ __ __ __ 2. Name of primary care physician: _____

3. Please list allergies (to medications, food, etc): _____ _____ _____
_____ _____ _____

4. If patient is female, has menstrual cycle begun? Yes, age of onset: _____ Last menstrual cycle? __ __/ __ __/ __ __ __ __
No Don't know

5. (Female) Does the patient use birth control medication? Yes No Don't know

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6. Does the patient have problems with any of the following physical systems (**list age of onset on line next to problem**)

Cardiovascular **Age of Onset**
- Heart problems _____
- Blood problems (anemia, hemophilia, thalesthomia, etc.) _____

Ears, Eyes, Nose, Throat
- Poor hearing _____
- Poor vision _____
- Speech problems _____
- Other _____ _____

Gastrointestinal
- Bowel incontinence _____
- Constipation _____
- Diarrhea _____
- Food intolerance _____
- Frequent nausea / vomiting _____
- Frequent stomach pain _____
- Other _____ _____

Genetic
- Down Syndrome
- Sickle Cell
- Fragile X Syndrome
- Other _____

Genitourinary
- Frequent urinary tract infections _____
- Kidney problems _____
- Urinary incontinence _____
- Other _____ _____

Immunological **Age of Onset**
- Autoimmune disorder (rheumatoid arthritis, etc.) _____
- Immune deficiency _____
- Other _____ _____

Metabolic
- Diabetes _____
- Thyroid _____
- Other _____ _____

Muscular / Skeletal
- Frequent muscle / joint pain _____
- Muscle weakness _____
- Bone disease _____
- Other _____ _____

Neurological
- Headaches _____
- Seizures _____
- Brain Injury _____
- Spinal Injury _____
- Paralysis _____
- Other _____ _____

Pulmonary / Respiratory
- Allergies _____
- Asthma _____
- Other _____ _____

NONE OF THE ABOVE

---

7. Which of the following illnesses has (s)he had?

mumps chicken pox measles whooping cough scarlet fever
pneumonia encephalitis seizures ear infections lead poisoning
rheumatic fever Other diseases (specify):_____ **none**

8. Has (s)he had any accidents resulting in the following?

emergency room treatment stitches broken bones head injury lost teeth
loss of consciousness severe bruises eye injuries stomach pumped **none**

9. How many accidents? 0 1 2-3 4-7 8-12 over 12

10a. Has (s)he had any of the following surgeries?

tonsillitis adenoids hernia appendicitis eye, ear, nose, & throat
urinary tract leg or arm burns other _____ **none**

b. How many times hospitalized? **none** once twice 3-5 times 6-8 times 8+

c. Longest hospitalization?

none 1 day 1 day & night 2-3 days 4- 6 days 1-4 weeks 1-2 months over 2 months

11. List any current and past medical or physical problems not asked already (including hospitalizations and traumas):

_____
_____

DEVELOPMENTAL

PRENATAL/PERINATAL HISTORY OF PATIENT:

1. How old was mother when child was born? _____ don't know
2. Did mother use any of the following medications or substances during pregnancy? don't know none

antidepressant medication	coffee or other caffeine	street drugs (please specify) _____
anti-anxiety medication	cigarettes	antibiotics
tranquilizers	alcohol	Rhogamm shots (for Rh factor incompatability)
sleeping medications	marijuana	Other (please specify) _____

3. During the pregnancy did the patient's mother have: no complications don't know

difficult pregnancy	high blood pressure	infections	other _____	
amniocentesis	diabetes	excessive	bleeding	

4. When was the child born? early on-time late Don't know
5. What was the child's birth weight? _____ lbs Don't know
6. Were there any indications of fetal distress during labor or birth? Yes No Don't know
7. Were forceps used? Yes No Don't know
8. Were there any health complications following the birth? Yes No Don't know

Oxygen required	Y / N	Needed IV	Y / N	Seizures/convulsions	Y / N
Jaundiced (yellow)	Y / N	Infection	Y / N	Other _____	Y / N
Cord around neck	Y / N	Incubated	Y / N		

POSTNATAL AND INFANCY:

1. Please check any of the following that applied to your child during infancy. **None**

Cried often and easily	Not affectionate	Hard to comfort or console	
Sleeping difficulties	Poor eye contact	Head banging	
Rocking	Floppy	Feeding problems	Colicky

2. Were there problems with the infant's responsiveness or alertness? Yes No Don't know
3. Did the child experience any health problems during infancy? Yes No Don't know
   If yes, specify_____
4. How would you describe your child as a baby?
   easy baby slow to warm up baby difficult baby
5. How well did the baby behave with other people?
   very sociable pretty sociable not very sociable not sociable at all
6. When (s)he wanted something, how insistent was (s)he?
   very insistent pretty insistent not very insistent not insistent at all
7. How would you rate the activity level of the child as an infant/toddler?
   very active pretty active not very active not active at all

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NUTRITIONAL HISTORY OF CHILD

1. Any problems with chewing/swallowing/choking/feeding? Yes No
2. Food allergies/intolerance? Yes No
3. Growth problems? Yes No
4. How often does the family (including the patient) eat together?
   2 or more times a day daily few times a week once a week once or twice a month never
5. On average, how many days a week does the child eat breakfast? 1 2 3 4 5 6 7

DEVELOPMENTAL MILESTONES

1. At what age did (s)he sit without support?
   before 5 months 5-7 months after 7 months don't know
2. At what age did (s)he walk?
   before 11 months 11-15 months after 15 months don't know
3. At what age did (s)he say first words?
   before 9 months 9 -16 months after 16 months don't know
4. At what age did (s)he speak putting two or more words together?
   before 17 months 17-26 months after 26 months don't know
5. At what age was (s)he toilet trained for bladder control?
   before 3 years 3-5 years after 5 years don't know
6. At what age was (s)he toilet trained for bowel control?
   before 2 years 2-4 years after 4 years don't know

CHILD'S SCHOOL HISTORY

1. Current school _____ Grade _____

   School District, State_____

   Phone number (__ __ __) __ __ __- __ __ __ __

   Homeroom teacher or counselor_____

2. How many schools has the child/adolescent attended? _____

3. If the child/adolescent is having problems in school, identify the areas: None

Math problems	Clumsy or uncoordinated
Reading problems	Truancy (skipping)
Spelling problems	Fights with peers
Writing problems	Fights with teachers
Language problems	Fear of school

4. Describe how teachers have explained the child/adolescent's problem(s)_____
_____
_____

5. Has (s)he ever been in any type of special education program? Yes No

What type?	resource class	speech/language therapy
	learning disabilities class	behavioral/emotional disorder class
	alternative class/school	self contained classroom
	504 program/Duration of placement:_____	

6. Current or previous Individual Education Plan (IEP) or 504 contract? Yes No

7. Has (s)he ever been?
   advanced in grade / which grades:_____
   suspended from school / number of times:_____
   expelled from school / number of times:_____
   failed a grade(s) / which grades:_____
   held back for other reasons
   None of the above

8. Overall, what level of academic performance does the patient achieve?
   straight A's A/B B/C C/D D/F Failing every class

9. Does (s)he participate in after school activities or activities outside of school? Yes No

If yes, please circle all that apply:	sports	the arts (music, art, drama, dance, etc.)	religious / cultural
	academic	community	scouts
	other _____		

SOCIAL HISTORY

1. Please list the names, ages and genders of the children in the patient's household and/or patient's siblings. None

Name	Date of Birth	Gender	Step/Biological/ Half/Adopted?	The child currently resides with…?
	_ _/_ _/_ _ _ _	M / F		
	_ _/_ _/_ _ _ _	M / F		
	_ _/_ _/_ _ _ _	M / F		
	_ _/_ _/_ _ _ _	M / F		
	_ _/_ _/_ _ _ _	M / F		
	_ _/_ _/_ _ _ _	M / F		

2. Does anyone else reside in the child's household (other than the parents)? If yes, please list names, ages, and relationship. None

Name	Date of Birth	Gender	Relationship to patient
	_ _/_ _/_ _ _ _	M / F	
	_ _/_ _/_ _ _ _	M / F	
	_ _/_ _/_ _ _ _	M / F	

3. How many times has the patient moved or had different primary caregivers since birth? ____

Dates lived there (of care) From (mo/year) To		Location	Reason for move / Change in caregiver
_ _/_ _ _ _	_ _/_ _ _ _		
_ _/_ _ _ _	_ _/_ _ _ _		
_ _/_ _ _ _	_ _/_ _ _ _		
_ _/_ _ _ _	_ _/_ _ _ _		
_ _/_ _ _ _	_ _/_ _ _ _		
_ _/_ _ _ _	_ _/_ _ _ _		

4. How does s(he) get along with his/her brothers/sisters?
doesn't have any better than average average worse than average

5. How easily does (s)he make friends?
very easily average difficulty making friends

6. How easily does (s)he keep friends?
very easily average difficulty keeping friends

7. How would you characterize the type of friends (s)he has?
positive influence neutral influence negative influence

8. What does (s)he do for fun? _____
_____

9. How many hours a day does (s)he spend watching TV? Is it monitored by an adult? Yes No
less than 1 hour 1-2 hours 3-5 hours 6-10 hours TV is always on

10. How many hours a day does (s)he spend playing computer/video games? Is it monitored by an adult? Yes No
less than 1 hour 1-2 hours 3-5 hours 6-10 hours over 10 hours

11. Is (s)he currently involved in the Juvenile Justice or Legal System? Yes No

In order to have a better understanding of the patient, it may help providers to understand some of the patient's guardian's history. Please answer the following questions with regard to the patient's current legal guardian, NOT the patient.

GUARDIAN'S EARLY FAMILY HISTORY (Answer about current legal guardian)

1. Who raised you (current legal guardian)? (Give relationship: biological parents, aunt, etc.) _____
2. Were you adopted? Yes No If so, at what age?_____
3. What was it like in your childhood home? (Please circle all that apply)
   loving comfortable supportive chaotic cold quarrelsome abusive
   other (please explain) _____
4. When you were born, were your parents living together not living together
5. Did your parents physically fight? never rarely sometimes often
6. How close were/are you to your father? close somewhat close somewhat distant distant Did not know him
7. How close were/are you to your mother? close somewhat close somewhat distant distant Did not know her
8. What kind of discipline was used in your home? (circle all that apply)
   verbal reprimands time out removal of privileges
   restrictions/grounding rewards spanking or other physical discipline
   assigning additional chores/tasks giving in to child avoiding child
9. Have you or other members of your family ever been physically abused? Yes No
10. Have you or other members of your family ever been sexually abused? Yes No
11. Was your family: poor lower middle class upper middle class wealthy

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OTHER CURRENT LEGAL GUARDIAN'S EARLY FAMILY HISTORY (Spouse/Partner)

1. Who raised the other current legal guardian? (Give relationship: biological parents, aunt, etc.) _____
2. Was he/she adopted? Yes No If so, at what age?_____
3. What was it like in his/her childhood home? (Please circle all that apply)
   loving comfortable supportive chaotic cold quarrelsome abusive
   other (please explain) _____
4. When he/she was born, were his/her parents living together not living together
5. Did his/her parents physically fight? never rarely sometimes often
6. How close was she/he to his/her father? close somewhat close somewhat distant distant Did not know him
7. How close was she/he to his/her mother? close somewhat close somewhat distant distant Did not know her
8. What kind of discipline was used in his/her home? (circle all that apply)
   verbal reprimands time out removal of privileges
   restrictions/grounding rewards spanking or other physical discipline
   assigning additional chores/tasks giving in to child avoiding child
9. Has he/she or other members of his/her family ever been physically abused? Yes No
10. Has he/she or other members of his/her family ever been sexually abused? Yes No
11. Was his/her family: poor lower middle class upper middle class wealthy

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CURRENT FAMILY (WITH WHOM THE PATIENT CURRENTLY RESIDES)

1. Select the category that best describes the total, combined income from all members of the patient's household last year:
   Less than $10,000 $30,000 to $39,999 $70,000 to $99,999
   $10,000 to $14,999 $40,000 to $49,999 $100,000 to $149,999
   $15,000 to $19,999 $50,000 to $59,999 $150,000 or more
   $20,000 to $29,999 $60,000 to $69,999

2. How long did the guardian date his/her spouse before getting married? _____ years _____ months N/A
3. Date of current marriage (month, day, year) __ __/__ __/__ __ __ __ N/A
4. Is the guardian currently living with his/her spouse/partner? Yes No
5. How many times has the guardian been married? ____ N/A
6. How many times has the guardian's spouse/partner been married? ____ N/A
7. How many times has the sponsor been married? ____ N/A
8. Has the guardian and/or any of his/her spouses ever been to counseling or an agency such as Child Protective Services or Family Advocacy because of physical, sexual, or emotional abuse? Yes No
9. Is the guardian presently having any problems with his/her parents or in-laws? Yes No

CURRENT FAMILY (cont'd)

10. What type of discipline does the patient's guardian(s) use (check all that apply)?

verbal reprimands	time out	removal of privileges
restrictions/grounding	rewards	spanking or other physical discipline
assigning additional chores/tasks	giving in to child	avoiding child

11. To what extent do the guardian and his/her spouse/partner agree on discipline?
0-20% of the time 20-40% 40-60% 60-80% 80-100%

12. How consistent are the guardian and his/her spouse/partner with discipline?
Very consistent Somewhat consistent Rarely consistent Not consistent at all

13. On average, what percentage of time does the patient comply with an initial request to do something?
0-20% 20-40% 40-60% 60-80% 80-100%

14. On average, what percentage of time does the patient eventually comply with a request to do something?
0-20% 20-40% 40-60% 60-80% 80-100%

15. Are there any firearms/guns in the home where the patient resides? Yes No

16. Does the patient have access to firearms/guns? Yes No

17. In the home where the patient resides the majority of the time, is the patient exposed to: (please circle yes or no)

tobacco Yes / No	violence Yes / No	sexually explicit behavior Yes / No
alcohol consumption Yes / No	violent shows/movies Yes / No	sexually explicit shows/movies/materials Yes / No

SPIRITUAL /CULTURAL

1. What is the guardian's religious/spiritual affiliation? / His/her spouse?

Catholic	Catholic
Protestant	Protestant
Jewish	Jewish
Islam	Islam
Hindu	Hindu
Buddhism	Buddhism
None	None
Other _____	Other _____

2. How much is your religion/spirituality a source of strength and comfort to you (parent/guardian)?
not at all not much some quite a bit a great deal

3. How important a part of your daily life is your religion/spirituality?
not at all not much some quite a bit a great deal

4. How important a part of your spouse's/partner's daily life is your spouse's/partner's religion/spirituality?
not at all not much some quite a bit a great deal

5. Is religion a source of conflict in the patient's home?
not at all not much some quite a bit a great deal

6. Does your child belong to any special groups, which relate to your ethnic background/ nationality or political/spiritual beliefs?
Yes No

7. Do you have any religious/spiritual practices that the provider needs to be aware of during treatment?
Yes No If yes, please explain: _____

END OF PATIENT QUESTIONAIRE

<u>ADDITIONAL ADDRESSES</u> – If the patient lives any part of the week or year at another address, please provide this additional information.

1. Street: _____

City:_____ State: ___ Zip Code:_____

Home Phone: (_ _ _) _ _ _ - _ _ _ _ email: _____

To whom does the address belong? (Name) _____

Relationship to Patient:

Biological Mother	Step Mother	Adoptive Mother
Biological Father	Step Father	Adoptive Father
Foster Father	Foster Mother	Grandparent
Aunt Uncle	Sister Brother	Other _____

Thank you for your patience in completing this form. If there is anything else we should know to help you or your child, please be sure to bring the issue to the attention of your provider.

CAPS Staff:_____ Date: _____